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ABSTRACT

This paper describes the efforts of the rural Pioneer Mental Health Center (PMHC), Seward, Nebraska, in the development of a community-based alcohol/drug prevention program. Part I focuses on the history and development of the prevention model, which emphasizes process-oriented activities to promote community identification and ownership of the problems and solutions. The five guidelines used in working with communities (i.e., community designated goals, total community representation, ongoing community participation, multiple approaches for multiple factors, and PMHC staff as facilitators) are stated and activities of the PMHC staff in three communities are described to illustrate the use of the guidelines. In part II, the characteristics of a community development model, focusing on process rather than specific prevention techniques, are given. The effectiveness of the process-oriented community development approach is discussed from both first and second order changes. Part III discusses the implications of a process-oriented model in the areas of implementation, funding, and evaluation. The discussion on implementation specifically focuses on agency history and orientation, staff roles, and community relations. A comment on successive revolutions in mental health practice and services concludes the paper. (BL)

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A COMMUNITY DEVELOPMENT MODEL FOR PREVENTION OF CHEMICAL ABUSE

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

This paper describes the efforts of a rural mental health center in the development of a community-based alcohol/drug prevention program. The experience of Pioneer Mental Health Center, Seward, Nebraska, provides an opportunity to examine the key issues of prevention approaches, and the practical implications of such programs for mental health centers. This presentation of the community development model involves three parts: (1) history and development of the model at Pioneer Mental Health Center; (2) the theoretical basis of the model; and (3) implications for community mental health centers in the areas of implementation, funding and evaluation.

Part I: Pioneer Prevention Model

The prevention model developed by Pioneer Mental Health Center (PMHC) is innovative in its emphasis on community development processes as a means of promoting prevention activities. Rather than focus on the delivery of time-limited educational programs or other traditional prevention activities, PMHC staff emphasize process-oriented activities that promote community identification and ownership of alcohol/drug abuse problems, community leadership, and community generated programs and solutions. Staff members serve as consultants or catalysts who serve the interests and needs defined by community groups.

The PMHC model of alcohol/drug prevention evolved directly from the staff's dissatisfaction with the results of previous prevention activities in the seven county catchment area. Over the years, staff members provided education and consultation to teachers, students, church groups, parent groups, service organizations, law enforcement agencies and others. Using lecture, film, written materials and skill training, the staff presented information on the incidence of chemical abuse, definitions, attitudes toward use, and treatment alternatives.

In spite of increasing community requests and caseloads, staff members recognized that community action was not increasing. Educational programs did not motivate groups to take further action. The communities still seemed to view alcohol/drug abuse as a matter of primary treatment for identified abusers and their families, rather than a potential focus of community effort.

For example, at the request of schools, staff provided educational sessions for junior and senior high school students on alcohol/drug abuse, and examination of attitudes and peer pressure. Positive contacts were made with students and staff, but the programs did not seem to result in continued study of the issues. School policies toward chemical abusers continued to be punitive rather than treatment-oriented and only a few schools incorporated drug/alcohol information into the curriculum.

PMHC staff began to realize that a different approach to the prevention of alcohol/drug abuse was needed. The new approach emphasizes the process of promoting community-based prevention rather than the specific content or format of the drug/alcohol programs. Five guidelines are used in working with communities (Community Organization Grant for Chemical Dependency Prevention, 1981). The guidelines are stated her briefly; they are explained further by the examples that follow. First, the goals for each prevention-related activity are designated by the community group requesting the program, rather than by PMHC staff. Second, staff foster the inclusion of representatives from many different subgroups in the community to insure that a variety of attitudes and opinions are expressed. Third, the staff promotes development of ongoing groups which can take responsibility for community planning. Fourth, the staff recognizes that alcohol/drug abuse results from multiple risk factors, not from any single causative factor; and that a variety of approaches are likely to be more successful than one single program. Fifth, PMHC staff serve as facili-

tators or technical resources for community groups but are not responsible for the selection of methods or potential solutions.

Activities by PMHC staff in three different communities illustrate the use of the guidelines to promote community development. In Community I, the staff followed the fifth guideline in their interactions with the community. The role of the staff was one of facilitator in the early planning stages, and expert/resource person in later stages. Despite a direct request from the school superintendent for an educational program for students, PMHC staff did not take sole responsibility for the program. By acting as facilitators, staff was able to foster inclusion of parents, teachers and clergy in the planning process (guideline two). Goals and activities were developed by the group, not by any one person or agency (guideline one).

As a result of three planning meetings, the group decided to postpone the school program and to organize a series of four, two hour workshops open to the community. PMHC staff coordinated and provided speakers and films for the workshop, tailored to the requests of the planning committee. Staff remained responsive to community requests throughout the series. For example, after the second workshop, the committee and other community members requested specific information on the identification and effects of illegal drug activity in their community. The county sheriff was called in to present this information for the third session. Other topics of the workshop included the examination of attitudes , patterns of chemical abuse, and treatment alternatives. The fourth session was highly participatory, emphasizing consideration of community responses to the problem.

Development of the planning group resulted in a variety of prevention-related activities and this group became the nucleus of an on-going group that attracted community interest (guidelines three & four). The interest developed

naturally from the core group's involvement and participation in the project. For example, in preparation for the workshop, the planning group decided to do a community survey of attitudes toward alcohol/drug abuse in the school and in the community. The survey was handed out to approximately 150 persons and drew the involvement of church and community groups. Almost the same number of surveys were returned, and the project had stirred community interest. By the time of the first workshop, local churches had organized to take turns providing refreshments, and Boy Scout troops set up chairs and tables. In a farming community of 800 people, 120 to 150 people attended each of four evening sessions during the summer. The planning group added members as a result of the workshop and the group continues to meet on a monthly basis and plans activities without PMHC staff.

In Community II, PMHC staff serves primarily as a facilitator and technical resource to an established group (fifth guideline). This community had already organized a group to study the problem of chemical abuse and to plan preventive approaches. Membership includes parents, teachers, law enforcement personnel, business operators, church leaders and a physician. One staff member participates in this group, but as a parent rather than an expert, and purposely takes a secondary role.

Recently school representatives contacted PMHC and requested teacher training of a very limited nature. The staff met with the guidance counselor, principal and two teachers to discuss needs. The PMHC staff asked that the community group be included in the next planning meeting (guideline two). The school staff agreed, although they felt the community group was moving too slowly. The representatives of the community group were initially quite hostile to the teacher training proposal and to the role of PMHC staff. They felt that the agency was attempting to control the educational process of the

community and that the school was not working with them cooperatively. PMHC staff facilitated a meeting between the two groups and helped them to discuss goals and to reach a consensus on the nature and extent of the training.

Community group members decided to attend the training and encourage teacher participation in the community group. The training provided by PMHC staff stressed the need for the community and the school staff to address policy issues and to decided on an appropriate course of action for the school system, in conjunction with parents and others. Prevention and identification models used in other schools were presented. No particular solution was proposed. Representatives of the community group were quite positive about the sessions and indicated they might request technical assistance. The school administration is considering intensive training in intervention techniques for a core group of teachers. Another small group is considering the revision of drug/alcohol policies in the school. The facilitative role of PMHC staff encouraged two significant community groups to begin the process of working cooperatively and of coordinating goals and activities.

In Community III, the role of PMHC staff is less direct and obvious than in the other two communities. The staff promoted the development of a very small self-help group for parents by informal interactions with one of the group leaders. The group leader is an office coordinator at PMHC and she frequently talks with staff members regarding goals, organizational issues, group dynamics and potential training needs. Staff members help clarify issues and offer suggestions and resource materials. With minimal staff assistance and encouragement the group was successful in obtaining a small grant from the State Division on Alcoholism & Drug Abuse. They have also generated substantial contributions from community members. A crisis support network for parents has

been formed and educational programs for the teachers, students and the community have been implemented. The group remains self-directed and active.

Part II: Characteristics of a Community Development Model

The community development model of prevention of chemical abuse is quite different from traditional prevention approaches. The new model addresses the process of developing prevention programs within the community, rather than the promotion of any specific prevention program. The community development model can be characterized as a process-oriented, rather than program-oriented approach to prevention. The two approaches, process and program-oriented, are compared in regard to theoretical assumptions, mechanics and potential effects.

Program-oriented prevention frequently addresses primary prevention issues. In the area of alcohol/drug abuse, the problem is often viewed as a lack of education, intervention skills, or treatment resources. Typically, mental health specialists are asked to devise a prevention program and then help the target Community or institution to implement it.

> As Swift (1981) points out, "...prevention programs in CMHC's are primarily focused on strengthening the individual or the target population rather than on changing system variables that may contribute to drug abuse" (p.30).

Swift reviewed the prevention efforts of CMHCs and found that they focus on information, skill-building, (problem-solving, interpersonal skills, coping with stress), or resistance to peer pressure. The mechanics of the decision to implement are not considered, nor is the structure of the system altered. As PMHC experienced it, a program might inform and educate students, but school policies remain punitive, discourage treatment and encourage student risk-taking.

In contrast, process-oriented prevention emphasizes principles of community

development rather than program development. Rothman's (1968) description of the community development paradigm applies well to the Pioneer program. According to Rothman, goals of locality development (Rothman's term), are the development of self-help attitudes, and integration and increase of community resources. It is assumed that the community is static and lacks adequate between-group relationships for problem-solving. Change strategy focuses on a broad cross-section of people involved in identifying and solving problems. A consensus approach is used to improve communication among factions and to form task-oriented groups. It is assumed that common interests can be used to resolve differences and to involve members of the power structure as collaborators. The practitioner's role is one of coordinator, catalyst, and teacher of skills.

The effects of process-oriented community development are significantly different than the results of program-oriented prevention. As PMHC staff began to operate on the basis of community development approaches, they began to bring groups together when local initiative was fragmented, and then withdrew to foster leadership from within the group. In Community I, PMHC staff was instrumental in involving other community groups with school personnel to form a task force, but has not assumed leadership of the continuing group. In Community II, a task force already existed, and PMHC staff encouraged the school staff to interact more directly with the task force. A PMHC staff member serves on the task force as a parent and community member, but purposely avoids a leadership role.

A community development model assumes that the community can act if alternatives are made available. The early prevention efforts of PMHC demonstrate that increased awareness and information about chemical dependency problems are not sufficient to motivate action. By using a community development

model in communities I, II, and III, the PMHC staff has furnished many ideas and alternatives which the groups have subsequently evaluated and utilized, as they deemed appropriate.

As Rothman points out, community development can foster cooperation among community officials and power sources, so that they become responsive to community initiatives. Early programmatic interventions by PMHC did not result in active involvement of members of the community power structure, but the actions of the community task forces have elicited their involvement.

The effectiveness of process-oriented community development approaches lies in their attention to system-wide variables. Program-oriented prevention often targets individual or group treatment foactors, while ignoring the rules governing the relationships between groups. Watzlawick, Weakland and Fisch (1974) differentiate between first and second-order change processes, a distinction that aptly explains the effectiveness of program versus process-oriented prevention.

First-order change is defined as change that occurs within a system, but does not substantially alter the outcomes of the system or the rules governing it. Second-order change refers to changes which alter the nature of the system itself. Watzlawick et al. apply this distinction to family systems. The application here suggests that program-oriented prevention is likely to result in first-order change. As experienced by PMHC, educational programs do not promote substantial community action or involvement. Individuals who participate in programs may benefit but the breader system, the institution or community itself, is not substantially affected.

Process-oriented community development approaches are more likely to produce second-order changes that can have wide-ranging effects because the

rules governing systems and relationships are considered. Preventive action taken at the wrong level will not produce change elsewhere in the system, and will not be maintained. For example, targeting students for drug prevention programs is unlikely to affect school policy or alter negative parental attitudes toward school policies. If parental attitudes are in open conflict with policies set by the school administration, students are likely to continue in behaviors contrary to school policy. A more powerful intervention would facilitate resolution of differences among parents, students, and school staff, so that mutually agreeable or tolerable policies are developed. As Rappaport (1977) states, "...preventive programs may still commit an error of logical typing by assuming that community difficulty may be solved by working only at the individual level. It is often likely that both individual and community level interventions are required, and it is community, organization, and institutional change which is most frequently ignored" (p. 139).

Similarly, the gradual formation of community task forces constitutes a second-order change tactic, as the group members struggle to redefine relationships with one another. The programs that the task forces have promoted are aimed at examination and resolution of community-wide differences regarding chemical dependency.

It would appear that a process-oriented prevention model is likely to result in second-order change. Community development techniques are conducive to bringing together various groups for consideration of the assumptions and rules governing relationships between groups. Interventions are more likely to be designed with regard to individual, organizational and institutional levels; as a result, crucial variables that maintain behaviors or systems are not as likely to be overlooked. At this point it is not yet known if current and future activities will result in second-order changes, but the potential exists.

If the community mental health centers continue to provide prevention ser-

vices, the preceding discussion suggests that they should consider a process-oriented model. To summarize, a process-oriented model is more likely than conventional efforts to: (1) enhance community identity and cohesion; (2) mobilize community resources; (3) enhance community ownership of the problem; and (4) foster activities that promote effective, long-range solutions of a preventive, second-order nature.

Part III: Implications of a Process-Oriented Model

Implementation of a process-oriented prevention model requires consideration of the practical implications for community mental health centers (CMHC) and their staff. The model demands special consideration of staff roles, community relations, funding and evaluations.

The experience of PMHC suggests that an agency must carefully assess the staff's willingness to adopt new roles, the history of the agency's relationships with the community, and the community's level of awareness and concern. All three factors interact to determine the potential for process-oriented approaches. The new approach requires that CMHC staff and the community must enter into a very different relationship than previously maintained. The role of CMHC worker is considerably changed. Rappaport (1977) has described the shift from a waiting to a seeking mode, implicit in the difference between traditional treatment and prevention activities. Staff must develop special skills, including expertise in public speaking, group facilitation, and systems analysis. Mental health professionals have been trained to deliver therapy and have received little guidance on delivering prevention services. Perhaps, essentially, staff must reorient their self-perceptions from that of expert to helper and facilitator. The tendency for the staff to promote hidden programs and goals, while outwardly promoting self-determination of communities, is likely to be strong, particularly when task forces seem to be floundering.

Transition to the new role and model can be facilitated by the relationships already established in the community. At Pioneer Mental Health Center, several years of community service and education had already established the staff as trustworthy individuals. The Center had become part of the communities, and was relied on by community institutions and agencies. The established relationships were an important advantage in attracting community caretakers to initial meetings.

The reliance on professional staff was actively channeled into community self-reliance as staff members attempted to facilitate group problem-solving and disengage themselves from decision making roles. Staff members refused to give answers or promote "solutions" and attempted to foster leadership among community members. The newness of the community-wide focus to staff and the search for new ideas were helpful in placing staff and community members on an equal footing. Staff could truthfully claim little expertise in formulating community interventions.

The conditions for acceptance of new approaches were present in most communities, since awareness and knowledge of alcohol/drug problems had been promoted by previous programs. Some key community persons already shared the staff's concerns about the limitations of previous programming.

Certainly the nondirective nature of process-oriented prevention and evaluation suggests a dilemma for professionals who use these approaches. For example, a community task force may decide to engage in activities that would appear to the professions as having little value or as promoting first-order change only. Groups can and do become self-perpetuating systems in which the major value is the enhancement of individuals within the group. Some professionals note that this may improve the mental health of the individuals. Miller and Reissman (1968) state that, "frequently an individual's psychological

difficulties appear to diminish when he becomes involved in some commitment, activity or social movement" (p. 179). The improvement is attributed to a spread effect: "...a self-generator of positive change is put into motion and it may lead the client to feel a growing sense of power and conviction which transfers to various areas of his life, his family, his friends, and the community, indirectly producing broad behavioral modifications and feedback effects" (p. 180).

While the spread effect is certainly worthwhile to the individual, it does not necessarily imply effective prevention of the community-wide problem. If no prevention effects are actually seen, the group process would have become a method of first-order change!

The right of community self-determination, a basic assumption of community development, implies that professionals must allow groups to potentially fail in achieving ultimate goals or to decide that the problem cannot or will not be pursued further.

The nature of process-oriented prevention raises an additional difficulty for staff in the area of evaluation. PMHC staff recognized the need to consider evaluation criteria and methods that would be meaningful in the context of the new prevention methods. Previously the number of staff presentations and of participants was considered to be a gage of effectiveness, along with participant ratings of the presentations on dimensions such as relevance, organization, and presentor characteristics. Staff members soon realized that these measures did not necessarily include the goals of a process-oriented approach. Staff decided to record, in case record fashion, instances of community organization and activities, and all staff contacts with community members. This information includes descriptions of membership of the community groups, and the current goals and activities of the groups. Other evaluation methods include an assessment of the phase or level of community development and an assessment of the groups potential for continued development.

This method of program evaluation is descriptive and is itself process-oriented (Stake, 1975). It allows documentation of staff activities while assessing continued progress towards goals as defined by each community. The focus of evaluation is on the second-order goal of community development, rather than on instances of first-order change.

Although staff and community factors will greatly influence the success of process-oriented approaches, the feasibility of adopting these methods may ultimately depend on the funding sources available to mental health centers. Curretnly, the national reimbursement system provides only for individual treatment. Prevention activities do not generate direct income through the existing health care system. Swift (1981) believes "it is likely that in the future the already limited resources devoted to the delivery of preventive services will further decline" (p. 36), as funding for human services declines overall.

PMHC applied for and received a prevention grant through the State Division of Alcoholism and Drug Abuse. The grant supports the cost of staff prevention activities, so that the agency's income is not soley tied to reimbursement for individual treatment. The grant is renewable but cannot be considered a permanent funding source.

The future of prevention efforts may rest on the communities' acceptance of responsibility for prevention efforts, and frank acknowledgement by CMHC workers of the need to address system-wide variables, CMHC workers and community workers must effect second-order change in the mental health care system if they wish to insure a shift from individually-oriented treatment to systems-oriented prevention. George Albee (1981), in discussing the establishment opposition which hinders development of prevention efforts by CMHC, sees in the struggle another significant change in the mental health field.

"The First Mental Health Revolution occured following the French

Revolution, when Philippe Pinel struck off the chains that bound the insane in the dungeons of Paris. Pinel confounded his critics, who predicted nothing but violence and disorder.

The Second Mental Health Revolution followed Freud's revelations about the unconscious origins of human behavior. This revolution led to the professional training of psychotherapists, to the development of theories of individual change....to the importance of insight...

The Third Mental Health Revolution came with the creation of the community mental health centers in 1965...conceived to provide an intervention alternative in the community and to reduce the custodialism of State hospitals through early intervention and follow-up care...

Now the mental health field appears to be on the threshold of the Fourth Mental Health Revolution. This revolution will emphasize social changes aimed at improving the quality of life and reducing avoidable stresses. It will challenge the authority of the mental health establishment and attack the ritualistic devotion to one-to-one intervention." (p. 42)

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